

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039148

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 155 Primary Registration District No. 4244 Registrar's No. 198

**FILED NOV 9 1962**

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jasper</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Jasper</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Cartersville</b>          |  | Length of stay in 1b<br><b>3 yrs.</b>  | c. CITY OR TOWN <b>Cartersville</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                      |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>321 W. Main</b> |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>321 W. Main St.</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|  |                              |   |   |   |   |
|--|------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Forest</b> Middle <b>Thornton</b> Last <b>Cornog</b>                     |                              |   | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>1</b> Year <b>1962</b> |   |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/28/1891</b>                                   | 9. AGE (last birthday)<br><b>70</b>                                     | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Owner and operator</b> |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Frosty's Place</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>Christian Co., Mo.</b> |   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |                              | 13a. FATHER'S NAME<br><b>Edward William Cornog</b>  |   |   |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>Mattie McReynolds</b>  |                              | 14. NAME OF HUSBAND OR WIFE<br><b>Jaunita Cornog, Cartersville, Mo.</b>   |   |   |   |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b> |  | 16. SOCIAL SECURITY NO.<br><b>[REDACTED]</b> |  | 17. INFORMANT<br><b>Jaunita Cornog, Cartersville, Mo.</b> |  |
|---|--|--|--|---|--|

|  |  |
|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bright's Disease</b><br>Interval between ONSET AND DEATH <b>18 Months</b> |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |  |

|   |  |  |  |
|---|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
|---|--|--|--|

|   |   |  |  |
|---|---|--|--|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |  |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m. Month, Day, Year _____                          |   |  |  |

|  |  |                              |        |       |
|--|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE |
|--|--|------------------------------|--------|-------|

|   |  |
|---|--|
| 21. I attended the deceased from <b>2-4-57</b> to <b>11-1-62</b> and last saw him alive on <b>11-1-62</b><br>Death occurred at <b>11:45</b> P.m. on the date stated above, and to the best of my knowledge, from the causes stated. |  |
|---|--|

|  |   |                                    |
|--|---|------------------------------------|
| 22a. SIGNATURE<br><b>James V. Flaherty, M.D.</b> | 22b. ADDRESS<br><b>319 W. Main St., Cartersville, Mo.</b> | 22c. DATE SIGNED<br><b>11-2-62</b> |
|--|---|------------------------------------|

|  |                               |  |  |
|--|-------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>11/5/1962</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Spokane Cemetery,</b> | 23d. LOCATION (City, town, or county)<br><b>Spokane, Mo.</b> |
|--|-------------------------------|--|--|

|  |  |   |
|--|--|---|
| 24. FUNERAL DIRECTOR<br><b>Hedge-Lewis</b> | 25. DATE RECD. BY LOCAL REG.<br><b>11-3-62</b> | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Madeline Switzer</b> |
|--|--|---|

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

**10490**

**20490**

**3**

**4 0**

**5 2**

**6**

**7 0**

**8 2**

**9593X**

**10**

**11**

**12 90-0**

**13 1-0**

DEC 5 1962

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Richard H. Lewis

Licensed Embalmer No. 4495

P. O. Address Webb City, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.